**Texas Department of Insurance**
*Division of Workers' Compensation*
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FONDREN ORTHOPEDIC GROUP LLP
7401 SOUTH MAIN
HOUSTON TEXAS 77030

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**Carrier's Austin Representative**
Box Number 19

**MFDR Tracking Number**
M4-12-1583-01

**MFDR Date Received**
January 12, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "carrier has not paid this procedure and code used is valid and no other code available to describe this procedure."

**Amount in Dispute:** $1,440.11

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The insurance carrier did submit a response to the DWC060 request. A copy of the DWC060 was placed in the carrier representative box 19 assigned to Flahive, Ogden & Latson on January 13, 2012. The DWC060 was picked up by Ben Zeigler on January 18, 2012. As a result, a decision will be issued based on the documentation available to Medical Fee Dispute Resolution at the time of the audit.

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 10, 2011 | 29999 x 2 | $1,440.11 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 3 – (189) Not otherwise classified or unlisted procedure code was billed when there is a specific procedure code for this procedure/service
   - 4 – Charged denied due to miscellaneous or unlisted code billed when the documentation supports use of a more specific existing procedure code (VB18)
   - 3 – (16) Claim/service lacks information which is needed for adjudication
   - 4 – This is an unlisted procedure. Please resubmit the bill with a more descriptive code or documentation

**Findings**

1. 28 Texas Labor Code §134.203 "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."
   - The requestor seeks reimbursement for CPT code 29999-LT and 29999-AS-LT rendered on June 10, 2011. The CPT® code description for 29999 is "Unlisted procedure, arthroscopy." The Medicare physician fee schedule does not value CPT code 29999 as a result, reimbursement is subject to the provisions of 28 Texas Administrative Code §134.1."
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(N)(ii), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (N) (ii).
5. 28 Texas Administrative Code §133.307(c)(2)(N)(iii), applicable to requests filed on or after June 1, 2012, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor's position for each disputed fee issue." Review of the submitted documentation finds that the requestor has the documentation supports the supports their position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c) (2) (N) (iii).
6. 28 Texas Administrative Code §133.307(c)(2)(O), applicable to requests filed on or after June 1, 2012, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | August 30, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.